

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

38891

State File No. ....

FILED DEC 1-1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 5537 Registrar's No. 71

1. PLACE OF DEATH a. COUNTY <u>Holt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Liberty Twp.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Liberty Twp.</u>	
c. LENGTH OF STAY (In this place) <u>1 yr.</u>		d. STREET ADDRESS (If rural, give location) <u>6 Miles N. of Mound City</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6 Mi. N. of Mound City</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Jeanie</u> b. (Middle) <u>Ann</u> c. (Last) <u>Kennish</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 23, 1953</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Aug. 10, 1952</u>	9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Thomas L. Kennish</u>	13b. MOTHER'S MAIDEN NAME <u>Mamie E. Brandon</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Thomas L. Kennish, Mound City, Mo.</u>	ADDRESS <u>Mound City, Mo.</u>
---	--	--	-----------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Convulsions</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congenital Brain Malformation</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>7531</u>			

19a. DATE OF OPERATION <u>Per 1953</u>	19b. MAJOR FINDINGS OF OPERATION <u>operation Mayo Clinic Congenital Brain Malformation</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 16, 1952 to 11-23, 1953 that I last saw the deceased alive on 11-22, 1953, and that death occurred at 12:39 m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. Perry, M.D.</u>	(Degree or title) <input type="checkbox"/> 23b. ADDRESS <u>Mound City Mo</u>	23c. DATE SIGNED <u>11-24-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11/24/1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Liberty Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Holt County, Missouri</u>

DATE REC'D BY LOCAL REG. <u>11/24/1953</u>	REGISTRAR'S SIGNATURE <u>James Crawford</u>	469	25. FUNERAL DIRECTOR'S SIGNATURE <u>James Crawford</u>	ADDRESS <u>Mound City, Mo.</u>
---	--	-----	---	-----------------------------------

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*James H. Crawford*

Licensed Embalmer No. 4796

P. O. Address Madison City, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.